YOUR MEDICAL OFFICE
PATIENT INFORMATION RECORD

PATIENT NAME: _____ HOME PHONE: (_____) _____-_____
LAST FIRST MI

STREET ADDRESS: _____ DATE OF BIRTH: ____/____/____ AGE: _____

CITY: _____ STATE: _____ ZIP: _____ SEX: M F

SOCIAL SECURITY #:_____ SCHOOL NAME:_____

PRIMARY CARE PHYSICIAN:_____ PHONE:(_____)_____-_____

REFERRING PHYSICIAN: _____ PHONE: (_____)_____-_____

RESPONSIBLE PARTY

NAME OF PARENT/GUARDIAN: _____

ADDRESS: _____CITY:_____ST:_____ ZIP: _____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #:_____ PHONE: (_____) _____-_____

EMPLOYER NAME/SCHOOL NAME: _____

OCCUPATION: _____

EMPLOYER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: (_____) _____-_____

OTHER PARENT'S NAME: _____

OTHER PARENT'S EMPLOYER: _____ PHONE: (_____) _____-_____

IF PARENTS ARE DIVORCED/SEPARATED WHO HAS CUSTODY? _____

PERSONS WHO HAVE ACCESS TO PATIENT'S MEDICAL INFORMATION: _____

PERSONS WHO HAVE LEGAL RIGHTS IN DECIDING PATIENT'S MEDICAL CARE: _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME: _____ INSURED PARTY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: (_____) _____-_____

GROUP #:_____ INSURED PARTY ID #:_____

INSURED PARTY SS#:_____ IN SURED DATE OF BIRTH: _____/_____/_____

INSURED EMPLOYER: _____ EMPLOYER'S PLAN: Y N

PATIENT'S RELATIONSHIP TO INSURED: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN PARENTS)

NAME: _____ PHONE: (_____) _____-_____

RELATIONSHIP TO PATIENT: _____

PLEASE NOTE: UNLESS PRIOR ARRANGEMENTS ARE MADE, PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED.
MEDICAL CARE: I authorize my physician to provide myself or my child with reasonable and proper medical care according to today's standards.
MEDICAL INFORMATION: I authorize the physicians and staff of this office to release any information they have acquired in the course of myself or my child's treatment to my insurance company, my employer or any third party payor so that they may obtain payment for medical services rendered.
INSURANCE AUTHORIZATION: I authorize the physicians of this office to furnish information to my insurance carriers concerning myself or my child's illness and treatments.
ASSIGNMENT OF BENEFITS: I authorize my insurance company or any third party payor to pay any benefits due directly to this office should they accept assignment on my claim. I ALSO AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN: _____DATE: _____/_____/_____